STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	MCTRICTION	(V2) DATE CLIDVEY
		II '	(X2) MULTIPLE CC		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155650	B. WING		09/19/2011
			STREET	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF F	PROVIDER OR SUPPLIEI	R	8380 V	IRGINIA ST	
LINCOLN	ISHIRE HEALTH C	ARE CENTER	MERRI	LLVILLE, IN46410	
(VA) ID	CLD O (A DV)	CTATE ADAT OF DEPLOYED OF		, <del>I</del>	(7/5)
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	NCY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	BEITEERCT	DATE
K0000					
		~	*****	1	
	A Life Safety Code Recertification		K0000		
	and State Lice	ensure Survey was			
	conducted by	the Indiana State			
	_	f Health in accordance			
	with 42 CFR				
	With 42 Cl IC	+63.70(a).			
	Survey Date:	09/19/11			
	-				
	Facility Numb	per: 000577			
	Provider Num				
	AIM Number	: 100266950			
	Surveyor: Ric	chard D. Schade, Life			
	Safety Code S	· · · · · · · · · · · · · · · · · · ·			
	Safety Code S	specialist			
	At this Life Sa	afety Code survey,			
	Lincolnshire I	Health Care Center			
		t in compliance with			
	Requirements	for Participation in			
	Medicare/Med	dicaid, 42 CFR			
		70(a), Life Safety from			
	•	•			
	Fire and the 2000 edition of the				
	National Fire	Protection			
	Association (	NFPA) 101 Life			
	Association (NFPA) 101, Life				
	Safety Code (LSC), and 410 IAC				
	16.2. The 198	84 building was			
	surveyed with	Chapter 19, Existing			
		T · · · · · · · · · · · · · · · · · · ·			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KLG421

Facility ID:

000577

If continuation sheet

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	01	COMPI	LETED
		155650	B. WIN			09/19/2	2011
		<u> </u>	B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEI	R		1	RGINIA ST		
LINCOLN	NSHIRE HEALTH C	ARE CENTER			LLVILLE, IN46410		
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· `	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Health Care C	· · · · · · · · · · · · · · · · · · ·					
		recupancies					
	This one story facility was						
	determined to be of Type V (111)						
	construction a						
		The original building					
	_	_					
	was constructed in 1984. The						
	facility has a fire alarm system with						
	smoke detecti	on in the corridors					
	and spaces op	en to the corridors.					
	The facility ha	as a capacity of 100					
	1	sus of 79 at the time					
	of this survey.	•					
	Quality Review by	Robert Booher, Life Safety					
	Code Specialist-Me	edical Surveyor on 09/23/11.					
	The feether						
	1	as found not in					
	compliance w						
	aforemention	ed regulatory					
	requirements	as evidenced by the					
	following:	- J					
	ionowing.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KLG421

000577

Facility ID:

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155650		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  01	(X3) DATE ( COMPL 09/19/2	ETED	
	PROVIDER OR SUPPLIER		•	8380 VIF	DDRESS, CITY, STATE, ZIP CODE RGINIA ST LVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
K0017 SS=E	walls constructed resistance rating, partitions are only passage of smoke buildings, walls proceiling. (Corridor underside of ceilin permitted by Code stations, waiting a activity spaces may under certain cond Gift shops may be by non-fire rated was prinklered.) 19 Based on obseinterview, the ensure 1 of 1 r separated from partition capally passage of smooth Exception. LS Exception # 6, patient sleeping rooms, and has open to the condition onto in the same compartment as electrically supports to the control of the compartment as electrically supports which is the compartment as t	facility failed to ecception offices was a the corridor by a ble of resisting the oke, or met an SC 19-3.6.1, Spaces other than g rooms, treatment zardous areas may be rridor and unlimited ed: (a) The space and h the space opens ne smoke are protected by an opervised automatic on system, and (b)	KO	0017	K 017 The filing of this plan correction does not constitute admission that the alleged deficiency did in fact exist. T plan of correction is filed as evidence of the facility's desi comply with the regulatory requirements and to continue provide quality care. Corridor separated from use areas by walls constructed with at leas hour fire resistance rating. To ensure compliance, the facilithave an electrically supervise automatic smoke detector installed in the reception offic area. A bid will be obtained the installation by 10/19/11 a plan in place for installation following receipt of the bid. Maintenance will audit all corridors to ensure compliance Life Safety Code. Monitoring be through the Monthly Audit the TELS Program. Administ will make a monthly review of TELS Program to ensure factors.	e an This This This This This This This This	10/19/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KLG421 Facility ID:

000577 If continuation sheet

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	(X3) DATE SURVEY COMPLETED 09/19/2011
	PROVIDER OR SUPPLIER		8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST ILLVILLE, IN46410	<b>'</b>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
	automatic spri space is arrang access to requirement (a 19-3.6.1 was refired area was electrically sugsmoke detection acknowledged supervisor at to observation.	nklers, and (c) The ged not to obstruct fired exits. This fice could affect all functed through the in the event of an de:  bservation with the fire at the main double sliding glass corridor. There was fish gap between the fanes. Exception # 6, a) of the LSC Section for met in that the senot protected by an opervised automatic for system. This was by the maintenance		is staying compliant. Environmental Consultants review TELS and monitor to facility for compliance during routine visits.	s will he
	3.1-19(b)				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155650		(X2) MULTIPLE  A. BUILDING  B. WING	01	(X3) DATE COMP 09/19/2	LETED	
	PROVIDER OR SUPPLIER		8380	ET ADDRESS, CITY, STATE, 1 D VIRGINIA ST RRILLVILLE, IN46410	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
K0027 SS=E	a 20-minute fire present least 13/4-inch thick Non-rated protection 48 inches from the permitted. Horizon with 7.2.1.14. Document of swing with egree not required. 19 Based on obsestinterview, the ensure 1 of 8 standard doors would read for a This deficient all residents, so the A wing of the A wing of the Findings inclusion. Based on obsestinterview in the A wing of the A wing	ing doors are not required as and positive latching is .3.7.5, 19.3.7.6, 19.3.7.7 rvation and facility failed to ets of smoke barrier estrict the movement t least 20 minutes. practice could affect taff and visitors on the B hall.	K0027	comply with the requirements and provide quality of openings in smooth at least a 20-min protection rating staff will ensure a sealing holes in Fire Rated seal of make the repair. Supervisor will coof all Fire and Sr. Barrier door sets facility to ensure the passage of some be completed by Maintenance Sul make Monthly Fatels Program to corridors are proprotect the passage.	not constitute an me alleged fact exist. This is filed as facility's desire to regulatory d to continue to are. Door ske barriers have nute fire Maintenance compliance by the barrier doors. will be provided to Maintenance omplete a review moke Rated a throughout the protection from smoke. This will in 10/19/11. pervisor will accility Audits on o ensure all operly sealed to	10/19/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155650	A. BUILDING	01	COMPLETED 09/19/2011
		100000	B. WING	T ADDRESS, CITY, STATE, ZIP CODE	00/10/2011
NAME OF I	PROVIDER OR SUPPLIER		l	VIRGINIA ST	
	NSHIRE HEALTH CA	ARE CENTER		RILLVILLE, IN46410	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
mo		servation, he was not		review of the TELS Program ensure audits are being completed. Environmental Consultants will review TELS Program and monitor the factor compliance during routine visits.	to S ility
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Based on observation and interview, the facility failed to ensure 2 of 11 hazardous room doors would close and latch automatically to prevent the passage of smoke. This deficient practice could affect residents, visitors and staff in and near the central supply storage room and mechanical room #3.		K0029	K 029 The filing of this plan of correction does not constitute admission that the alleged deficiency did in fact exist. It plan of correction is filed as evidence of the facility's desicomply with the regulatory requirements and to continue provide quality care. Hazard Areas are separated from other areas of the facility by doors self-closing devices. Mainter will ensure the Central Supp and Mechanical Room #3 has self-closing devices and ense each door closes and latches frame. This will be completed	e an This This This This This This This This

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ILTIPLE CON	STRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155650	A. BUIL	DING	01	COMPLI 09/19/20	
		199090	B. WINC	_		09/19/20	J11
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
LINCOLN	ISHIRE HEALTH CA	ARE CENTER			LVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG		-	DATE
	Based on observation with the maintenance supervisor on 09/19/11 at 12:40 p.m., the doors to the 10 by 10 foot central supply storage room containing cleaning supplies, equipment and boxes; and mechanical room # 3 which contained heating and cooling equipment did not have door closers and did not automatically close and latch. The maintenance supervisor acknowledged the problem areas at the time of observation.  3.1-19(b)				10/19/11. Maintenance Supervisor will make a review all Hazardous Room areas to ensure each has self-closing devices and each door close: automatically and latch. This review will be completed by 10/19/2011. Maintenance Supervisor will complete Mor Preventative Maintenance Au on TELS to ensure compliance Administrator will make a moreview of TELS Program to ensure audits are being completed on time. Environmental Consultants wimake a review of TELS Program during routine visits.	onthly dits ce. nthly	
K0038 SS=E	Exit access is arrareadily accessible with section 7.1.  Based on obsetinterview, the ensure exit egrows arranged that hazards in accessions.		K0	038	K 038 The filing of this plan of correction does not constitute admission that the alleged deficiency did in fact exist. The plan of correction is filed as evidence of the facility's desired comply with the regulatory requirements and to continue provide quality care. Exits are	e an his re to	10/19/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155650			LDING	NSTRUCTION  01	(X3) DATE COMPI 09/19/2	LETED	
	PROVIDER OR SUPPLIEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE RGINIA ST LLVILLE, IN46410	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) LEARS OF EGRESS FOR		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  arranged to be readily acce	IATE	(X5) COMPLETION DATE
	existing build with Chapter requires walk means of egre 7.1.6.2 throug Section 7.1.6. changes in ele exceed 1/4 inc 7.1.6.3 require be nominally 7.1.6.4 require be slip resistant conditions. To could affect an	ings shall comply 7. LSC Section 7.1.6 ing surfaces in the ss shall comply with h 7.1.6.4. LSC 2 requires abrupt evation shall not ch. LSC Section es walking surfaces to level. LSC Section es walking surfaces to nt under foreseeable his deficient practice my residents, staff and the A wing, B hall			at all times. Maintenance wobtain bids from an outside contractor and work will be scheduled by 10/19/11 to he repairs made to the concresurface to prevent a trip ha Maintenance will complete inspection of all exit egress walkways to ensure protect from trip hazards. This inspection of the completed by 10/19. Maintenance will perform to ensure continued compliance continued compliance of TELS proto ensure continued compliance. Environmental Consultants will review TEL monitor compliance during routine visits.	ave te zard. an tion pection /11. /lonthly ogram ance. nonthly	
	Findings include:						
	maintenance s 09/19/11 at 2: surface outsid wing, B hall e inch in width least one inch supervisor sta	ervation with the supervisor on 00 p.m., the concrete e the facility's A xit had a crack one with a depth of at . The maintenance ted at the time of the was aware of the					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
		155650	B. WING		09/19/2011
	PROVIDER OR SUPPLIER		8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, IN46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K0046 SS=F	duration is provided 19.2.9.1.  Based on record of facility failed to be generator room be tested annually for ensure the light with during periods of 100 of 100 resided requires emergen provided in according section 7.9.3 required shall be conducted emergency lighting intervals for not be annual test shall be required battery plighting system for hours. Equipment operational for the	g of at least 1½ hour and in accordance with 7.9.  review and interview, the ensure 1 of 1 emergency stattery backup lights was for a 90 minute duration to avould provide lighting a power outages to protect ents. LSC 19.2.9.1 and lighting shall be redance with Section 7.9. The provided in a functional test and on every required and system at 30 day dess than 30 seconds. And the conducted on every powered emergency for not less than 1 1/2 and shall be fully the duration of the test. Of visual inspections and	K0046	K 046 The filing of this plan of correction does not constitute admission that the alleged deficiency did in fact exist. It plan of correction is filed as evidence of the facility's desicomply with the regulatory requirements and to continue provide quality care. Emerglighting of at least 1½ hour duration is provided in accordance with 7.9. Monthly TELS task for Maintenance requires the routine testing for seconds along with an Annual test for 90-minute duration. It generator battery backup light was installed, at this facility, Spring Season of this year 2 therefore, there would be no documentation for the Annual Test at the time of this survey Maintenance will complete the Monthly and Annual TELS ta	e an This ire to e to gency  or 30 al The inting in the 011, al y. ne

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Event ID:

KLG421 Facility ID:

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If continuation sheet

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER  LINCOLNSHIRE HEALTH CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN46410	AND PLAN	NT OF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	COMPI 09/19/2	LETED
(VALID CUMA CAPA CAPATEMENT OF DEPLOYENCIES 15				STREET. 8380 V	'IRGINIA ST		
PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(EACH DEFICIEN			(EACH CORRECTIVE ACTION SHOUL)	O BE	(X5) COMPLETION DATE
tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors in the facility.  Findings include:  Based on review of the Preventive Maintenance supervisor on 09/19/11 at 11:20 a.m., it was documented the emergency generator room battery backup light was tested monthly but there was no documentation of an annual ninety minute test. The maintenance supervisor stated at the time of record review, the emergency generator battery backup light was not tested annually for a ninety minute duration.  3.1-19(b)	IAG	tests shall be kep inspection by the jurisdiction. This affect all resident facility.  Findings include:  Based on review Maintenance Log supervisor on 09/was documented room battery bac monthly but there of an annual nine maintenance supof record review, battery backup ligannually for a nine inspection.	t by the owner for authority having s deficient practice could its, staff and visitors in the of the Preventive g with the maintenance (19/11 at 11:20 a.m., it the emergency generator kup light was tested e was no documentation ety minute test. The ervisor stated at the time, the emergency generator ght was not tested	IAG	testing the emergency be lighting as scheduled. Administrator will make a review of the TELS audit continued compliance. Environmental Consultar make a review of TELS and monitor facility comp	a monthly s ensure nts will Program	DATE

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155650			(X2) MUI A. BUILI B. WING	DING	01	(X3) DATE S COMPL 09/19/2	ETED
	PROVIDER OR SUPPLIER			8380 VIF	DDRESS, CITY, STATE, ZIP CODE RGINIA ST LVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0051 SS=F	according to NFPA Code, to provide eany part of the bui complete fire alarm alarm initiation, au extinguishing systim patient sleeping provided that man 200 feet of nurse's located in the path written records of reliable second so Fire alarm system accordance with Normaintenance are kis remote annuncia system to an appropriate to an appropriate of the systems in accordance National Fire Ala NFPA 72, 1-5.2.5 circuit disconnected marking, sha authorized person identified as FIR CONTROL. This affect all residents staff.  Findings include	ces or equipment is installed A 72, National Fire Alarm effective warning of fire in Iding. Activation of the in system is by manual fire atomatic detection or em operation. Pull stations areas may be omitted ual pull stations are within a stations. Pull stations are in of egress. Electronic or tests are available. A surce of power is provided, as are maintained in IFPA 72 and records of tept readily available. There ation of the fire alarm oved central station.  Action and interview, the maintain 1 of 1 fire alarm dance with NFPA 72, arm Code, 1999 Edition.  5.2 requires the fire alarm tring means shall have a ll be accessible only to mel, and shall be E ALARM CIRCUIT is deficient practice could its as well as visitors and	K00	051	K 051 The filing of this plan of correction does not constitute admission that the alleged deficiency did in fact exist. T plan of correction is filed as evidence of the facility's desi comply with the regulatory requirements and to continue provide quality care. A fire all system with approved components, devices or equipment is installed accord to NFPA 72, National Fire Alac Code. Maintenance will ensure circuit breaker for Fire Alarm Panel is marked in red and labeled as required. This will completed by 10/19/11. Maintenance Supervisor will ensure routine audits are completed in a timely matter TELS Program. Administrators	e an This This This This This This This This	10/19/2011

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155650		(X2) M A. BUII B. WIN	LDING	NSTRUCTION  01	(X3) DATE S COMPL 09/19/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE RGINIA ST LVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
V00/4	located in the embox lacked ident maintenance sup of observation, halarm circuit bres.  3.1-19(b)	em system circuit breaker bergency power breaker ification. The ervisor stated at the time e was not aware the fire aker was to be identified			make a monthly review of th TELS Program to ensure aud are being completed timely. Environmental Consultants we review TELS and monitor factory compliance during routine vision.	dits vill sility	
K0064 SS=E	health care occup 9.7.4.1. 19.3.5.6 Based on obse interview, the ensure 1 of 1 extinguishers in readily identification backup to the suppression sy 1998 Edition, extinguishers in conspicuously states the auto- system is to be using the fire of	ancies in accordance with 5, NFPA 10 rvation and facility failed to portable fire in the kitchen was ied as a secondary automatic fire estem. NFPA 10, 2-3.2.1 requires fire to include a placed placard which matic fire protection e activated before extinguisher. This ice affects all staff in itchen.	K	0064	K 064 The filing of this plan of correction does not constitute admission that the alleged deficiency did in fact exist. T plan of correction is filed as evidence of the facility's desi comply with the regulatory requirements and to continue provide quality care. Portab fire extinguishers are provide all health care occupancies in accordance with 9.7.4.1. Maintenance will ensure fire extinguisher in dietary is propidentified as secondary back suppression system. Placard shall state: "Automatic fire protection system is to be activated before using fire extinguisher". This placard w installed by 10/19/11. Maintenance will ensure compliance through completi routine Monthly audits on TE Program. Administrator will n	e an his re to le to le d in n perly up to ill be on of LS	10/19/2011

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		II 155650 I		A. BUILDING 01			COMPLETED	
				B. WING			09/19/2011	
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER			l				
LINCOLNSHIRE HEALTH CARE CENTER			8380 VIRGINIA ST MERRILLVILLE, IN46410					
			WERRICLVILLE, IN40410					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION		BE COMPLETION PRIATE		
PREFIX			CROSS-REFERENCED TO THE APP		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
	Based on observation with the maintenance supervisor on 09/19/11 at 2:35 p.m., a placard was not placed near the Class K extinguisher in the kitchen. The maintenance supervisor stated at the time of observation, he was not aware of the requirement.				a monthly review of the TELS Program to ensure compliance Environmental Consultants we review TELS Program and monitor compliance during routine visits.	ce.		
K0000	A Life Safety Code Recertification and State Licensure Survey was		K0000					
	conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).  Survey Date: 09/19/11  Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950							
	Surveyor: Ric	hard D. Schade, Life						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP!		ULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION				A. BUILDING 02			COMPLETED	
		155650	B. WIN				9/2011	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODI			
LINCOLNSHIRE HEALTH CARE CENTER				1	RGINIA ST LLVILLE, IN46410			
					LLVILLE, IN40410		1 770	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION	
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE	
	Safety Code S	Specialist						
		Safety Code Specialist						
	At this Life S	afety Code survey						
	At this Life Safety Code survey,							
	Lincolnshire Health Care Center was found in compliance with							
		•						
	_	s for Participation in						
	Medicare/Medicaid, 42 CFR							
	Subpart 483.70(a), Life Safety from							
	Fire and the 2000 edition of the							
	National Fire Protection							
	Association (NFPA) 101, Life							
	Safety Code (LSC), and 410 IAC							
	16.2. The Therapy Room was							
	added to the original 1984 building							
	in 2009 and w	in 2009 and was surveyed with						
		Chapter 18, New Health Care						
	Occupancies							
	Georganicies							
	This one story facility was							
	determined to be of Type V (111)							
	1							
	construction and was fully							
	sprinklered. The Therapy Room							
	was constructed in 2009. The							
	facility has a fire alarm system with							
	smoke detection in the corridors							
	and spaces open to the corridors.  The facility has a capacity of 100 and had a census of 79 at the time of this survey.							
	<u> </u>							

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		02	(X3) DATE SURVEY COMPLETED 09/19/2011	
NAME OF PROVIDER OR SUPPLIER  LINCOLNSHIRE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  8380 VIRGINIA ST  MERRILLVILLE, IN46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF		ATE	(X5) COMPLETION DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KLG421

Facility ID: 000577

If continuation sheet

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